aetna™ Enrollment/Change Request

Aetna Health Inc.
1425 Union Meeting Road
Blue Bell, PA 19422
(800) 872-3862

Instructions: *Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.*

Employer group information – To be completed by employer.

Control	Suffix	Account	Plan number
Group number			**Class code**

Group / employer name – full name of business or organization

A. Type of activity – Employee completes sections A – D and the employee signature section. *Please print clearly.*

Enrollment
☐ New enrollee / subscriber

Effective date:
_____/_____/_____

Date of hire:
_____/_____/_____

Change – *Check all that apply.*
☐ Add spouse / domestic partner
☐ Add dependent child
☐ Name change
☐ Other
☐ Change plan:
_____
☐ Control / Suffix / Acct / Plan:
_____
Date of event: _____
Reason: _____

Remove or terminate –
Check all that apply.
☐ Remove spouse / domestic partner
☐ Remove dependent child
☐ Employee withdrawal / termination

Effective date: _____
Reason: _____

Continuation of coverage, i.e., COBRA, state
Not all options are available. Contact employer for available options.
Coverage for: ☐ Employee ☐ Dependents
Length of continuation (months):
☐ 18 ☐ 36 ☐ Other ____
☐ 29 – Attach disability determination from the Social Security Administration
Date of loss of coverage: _____
Date of qualifying event: _____
Continuation of coverage expiration date:
_____

B. Employee information

Social Security number	Last name, first name, middle initial		Home telephone ( ) -
Home address	Apt. number	City, state	ZIP code
Employer name			Work telephone ( ) -
Work address		City, state	ZIP code

C. Plan options – Your selection(s) must be offered by your employer.

☐ HMO ☐ QPOS® ☐ Aetna Health Network Option℠
☐ Aetna Open Access® HMO ☐ Aetna Health Network Only℠
☐ Aetna Choice® POS

Indicate plan name

Primary copay
☐ $5 ☐ $10 ☐ $15 ☐ Other $ ____

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

D. Individuals covered - *List individuals for whom you are adding / changing / removing coverage. For dependents over age 26, please refer to the instructions on the back of this form.* **Provide details for "Yes" responses below.*

1	**(A)**dd **(C)**hange **(R)**emove ____	**Employee name** (Last name, first name, middle initial)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number		Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **N/A**	Student **N/A**	Dental office ID number *(if applicable)*	Current patient **Yes** ☐
Primary medical office ID number *(if applicable)*		Physician first and last name				Provider ID number	Current patient **Yes** ☐

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Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.

D. Individuals covered - ***List individuals for whom you are adding / changing / removing coverage. For dependents over age 26, please refer to the instructions on the back of this form.*** ****Provide details for "Yes" responses below.***

2	**(A)**dd **(C)**hange **(R)**emove ____	**Spouse / domestic partner name** (Last name, first name, middle initial)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐	Dental office ID number *(if applicable)*		Current patient **Yes** ☐
Primary medical office ID number *(if applicable)*		Physician first and last name			Provider ID number		Current patient **Yes** ☐

3	**(A)**dd **(C)**hange **(R)**emove ____	**Child name** (Last name, first name, middle initial)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐	Dental office ID number *(if applicable)*		Current patient **Yes** ☐
Primary medical office ID number *(if applicable)*		Physician first and last name			Provider ID number		Current patient **Yes** ☐

4	**(A)**dd **(C)**hange **(R)**emove ____	**Child name** (Last name, first name, middle initial)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐	Dental office ID number *(if applicable)*		Current patient **Yes** ☐
Primary medical office ID number *(if applicable)*		Physician first and last name			Provider ID number		Current patient **Yes** ☐

5	**(A)**dd **(C)**hange **(R)**emove ____	**Child name** (Last name, first name, middle initial)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐	Dental office ID number *(if applicable)*		Current patient **Yes** ☐
Primary medical office ID number *(if applicable)*		Physician first and last name			Provider ID number		Current patient **Yes** ☐

6	**(A)**dd **(C)**hange **(R)**emove ____	**Child name** (Last name, first name, middle initial)				Sex (M/F)	**Birthdate** (MM/DD/YYYY) / /
Social Security number	Other medical coverage **Yes*** ☐	Other Rx drug coverage **Yes*** ☐	Handicapped **Yes** ☐	Student **Yes** ☐	Dental office ID number *(if applicable)*		Current patient **Yes** ☐
Primary medical office ID number *(if applicable)*		Physician first and last name			Provider ID number		Current patient **Yes** ☐

7. If **yes** to **Other medical coverage** above, provide effective dates, name and policy number of insurance carrier, HMO, or other source and your **member identification number**.

8. If **yes** to **Other Rx drug coverage** above, provide effective dates, name and policy number of insurance carrier, HMO, or other source and your **member identification number**.

9. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If **yes**, who and what address? Explain the circumstances.

10. If any dependent's last name differs from yours, explain the circumstances.

11. Is your spouse / domestic partner employed? ☐ Yes ☐ No If **yes**, provide name and address of spouse / domestic partner's employer.

Conditions of enrollment

Applicant acknowledgments and agreements

On behalf of myself and the dependents listed in section D, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna").
   - HMO / Aetna Health Network Only: Aetna Health Inc.
   - QPOS / Aetna Choice POS / Aetna Health Network Option: Aetna Health Inc., and / or Aetna Health Insurance Company of New York.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment / Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment / Change Request form, including those involving mental health, substance abuse and HIV / AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse / domestic partner and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents, nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

☐ *By checking this box you agree to use our member self-service website for all future printed materials and understand you may choose to receive paper documents in the future.*

Employee signature

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a member services representative at 1-800-323-9930 before signing this form.

I represent that all information supplied in this form is true and complete to the best of my knowledge and / or belief. I have read and agree to the Conditions of enrollment on this Enrollment / Change Request form.

Misrepresentation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Employee signature *- required*	***Date*** *(Month/Day/Year)*	***Employee email address*** *(optional)*	***Primary language spoken***
X			

Instructions

Employer – Complete the **Employer group information** at the top of the form.

Employee – Complete sections A – D and the Employee signature section.

Section A – Type of activity:

- Check box(es) indicating reason(s) for submitting this Enrollment / Change Request.
- Provide Effective date(s) and Date of event(s) where requested.

Section B – Employee information: Complete **all** information in order for your Enrollment / Change Request to be processed.

Section C – Plan options:

- Select only an option offered by your employer.
- Where applicable, indicate Plan option name and check *one* Primary copay.

Section D – Individuals covered:

- Add / Change / Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security number for each individual listed.
- If you or your dependent(s) have **Other medical coverage**, check the **Yes** box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **member identification number** for the insurance plan in the space provided in number **7**.
- If you or your dependent(s) have **Other Rx drug coverage**, check the **Yes** box and provide beginning and ending effective dates, name and policy number of insurance carrier, HMO or other source and your **member identification number** for the insurance plan in the space provided in number **8**.
  - **NOTE:** In some instances your medical carrier will differ from your Rx drug carrier.
- If a dependent is handicapped and financially dependent, check **Yes** and provide proof of handicapped status from the attending physician.
- If a dependent is a full-time student under the age of 26, check **Yes**. ***For information on coverage of dependents over age 26 contact your employer.***
- Dental office ID number: Locate the office ID number for the dentist (if applicable) from the appropriate provider directory or from the online provider directory at **www.aetna.com**.
  - If you are a current patient, please check the **Yes** box under Current patient.
- Primary medical office ID number: Locate the office ID number for the primary care physician from the appropriate provider directory or from the online provider directory at **www.aetna.com**.
  - Provide physician's first and last name and Provider ID number.
  - If you are a current patient, please check the **Yes** box under Current patient.

Employee signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment / Change Request in order for it to be processed.
- By checking the box in this section you agree to use our member self-service website for all future printed materials and understand you may choose to receive paper documents in the future.